Health Maintenance Questionnaire

12 MONTHS

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

PARENTS' CONCERNS

List concerns you have? 1.
2.
3.
4.
5.

Please check any body areas that concern you:

☐Head	☐Heart	☐Bones	☐Hormones
☐Eyes	☐Lungs	☐Joints	☐Blood
☐Ears	☐Intestines	☐Muscles	☐ Glands
☐Nose	☐Kidneys	☐Brain	☐Immunity
☐Mouth	☐Genitals	☐Nerves	
☐Throat	☐Skin	☐Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION

HISTORY

Describe any recent injuries or illnesses:

List medications taken routinely: ☐none

Note any new stresses in the family:

Is your baby in day care? ☐No ☐Yes ☐Nanny

How many kids in the room/home? _____

Are there smokers in your baby's home or day care? ☐No ☐outside ☐other room

Y N

☐☐Has baby been to a dentist yet?

Dental visits are recommended within 6 months of the first tooth erupting, so 12months old is typical. Clean teeth regularly. Never allow a bottle in bed or continuous suckling during the night, as this contributes to cavities.

- Avoid 2nd hand smoke.

NUTRITION

Nurses _____ times per day Pumps _____ ounces per day

OR

Stopped breastmilk when baby was _____ months old.

How many ounces per day of Whole milk: _____ Juice: _____

How many servings per day of Meat:_____ Fruit: _____ Veggies: _____

Y N

☐☐Are meals and snacks fairly well scheduled?
☐☐Has your child tolerated all foods introduced?
☐☐Is s/he finger feeding a variety of foods, mostly from the table?
☐☐Does s/he drink from a cup?

How many bottles does baby take per day? _____

BREAST FEEDING RECOMMENDATIONS

- 4-12 feedings in 24hrs is typical
- Should sleep through the night.
- May follow lower % on the weight growth curve
- Nurse as long as desired
- When ready, wean gradually and gently
- Needs 16-24oz of milk per day, plus other protein.
- Nursing for comfort is common.
- Vitamins as prescribed by the doctor.

GENERAL FEEDING RECOMMENDATIONS

- Increasing appetite fluctuations.
- Whole milk until age 2.
- Limit juices.
- Wean from bottle.
- Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins.
- Vitamins only if prescribed by the doctor.

Does your child pass stools without problems? ☐Yes ☐No

PHYSICAL EXAM

Ht_____ Wt_____ HC_____ VS:_____

EXAM:

Lab/Immunizations

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

Patient Name: Birth Date:

Do you have concerns about your child's vision or hearing? ☐Yes ☐No 12 month

DEVELOPMENTAL ASSESSMENT

☐Yes ☐No Are you concerned about your child's development?

MOTOR

Y N
- ☐☐Does baby pull to a stand?
- ☐☐Does s/he cruise around furniture?
- ☐☐Does your baby walk? ☐with help ☐alone
- ☐☐Does s/he pick up small items with thumb and finger?
- ☐☐Does s/he put one object inside of another?

LANGUAGE

Y N
- ☐☐Does s/he say "MAMA and DADA" and try to imitate words?
- ☐☐Do you repeat his/her words using proper enunciation?
- ☐☐Do you encourage speech by talking and singing?
- ☐☐Do you read books with real life pictures?
- ☐☐Does your baby wave "bye-bye?"
- ☐☐Do you limit TV to less than 2 hours per day?

SOCIAL

Y N
- ☐☐Does baby look for a dropped or hidden object?
- ☐☐Does s/he play peek-a-boo, pat-a-cake and so-big?
- ☐☐Does baby come when called?
- ☐☐Do you encourage your baby to play alone to foster independence?

BEHAVIOR RECOMMENDATIONS

☐Yes ☐No Are you concerned about your child's behavior?

If these were reviewed previously, check this box. ☐
You may skip to the "Sleep" box.

Y N
- ☐☐Is your baby becoming more independent? (normal)
- ☐☐Is your discipline consistent? (very important)
- ☐☐Do you show affection regularly?
- ☐☐Do you praise good behavior frequently? (time-in)
- ☐☐Do you remove attention when doing unacceptable behavior?
- ☐☐Do you set limits and choose your battles wisely?
- ☐☐Do you occasionally say "no?"
- ☐☐Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?
- ☐☐Do you try to ignore tantrums? (very typical)

SLEEP

Y N
- ☐☐Does your baby sleep well? (Separation anxiety may cause sleep problems.)
- ☐☐Do you maintain a bedtime routine?
- ☐☐Do you offer a security toy/blanket for awakenings?
- ☐☐Does your baby nap twice daily? (typical)
- ☐☐Are you OK with your baby's use of self-comforting behaviors? ☐thumb sucking ☐pacifier ☐favorite object? ☐None

Where does baby usually sleep?

SAFETY AWARENESS

The shaded items are new for the 12 month visit.

2019 Nebraska Car Seat Law: Kids ride rear-facing until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer. Kids under 8 must ride in the back seat.

Y N
- ☐☐Is the car seat rear facing in the back seat?
- ☐☐Do you keep your child away from machinery/tractors/mowers?
- ☐☐Do you monitor him/her for climbing into dangerous situations?
- ☐☐Do you have the Poison Control center number handy?
- ☐☐Are medications, poisons and plants out of reach?
- ☐☐Do you always monitor your child while s/he is in the bath tub?
- ☐☐Do you watch closely around lakes, wells, buckets and toilets?

Y N
- ☐☐Do you have gates to guard the stairs?
- ☐☐Are sharp table edges protected?
- ☐☐Do you keep small items out of reach which baby could choke on?
- ☐☐Do you check toys for breakage that may be hazardous?
- ☐☐Do you keep balloons and plastic wrappers away from your child?
- ☐☐Is the water temperature in your house less than 120 degrees?
- ☐☐Do you have a fire escape plan?
- ☐☐Do you check your smoke detectors regularly?
- ☐☐Do you keep your curling iron out of reach?
- ☐☐Do you limit sun exposure?
- ☐☐Have you inserted electrical outlet covers?
- ☐☐Do you watch for frayed electrical cords in need of repair?

Tuberculosis (TB) RISK

TB Risk: ☐High ☐Low

Y N
- ☐☐Has your child been around anyone with contagious TB or a positive PPD test?
- ☐☐Has your child had contact with people from Asia, Middle East, Africa or Latin America?
- ☐☐Is anyone living in your house infected with HIV?
- ☐☐Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers.
- ☐☐Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?

LEAD RISK

Lead Risk: ☐High ☐Low

Y N
- ☐☐Does your child live in or visit a house built before 1978?
- ☐☐Is there a sibling or playmate with lead poisoning?
- ☐☐Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways?
- ☐☐Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?
- ☐☐Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?

Who answered the above questions? *Thank you for helping us help you and your child!!*